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Regulation of Advanced Critical Care Practitioners: Past, present and future

Johan Campbell

Abstract

The role of Advanced Critical Care Practitioners was included in the Department of Health's recent consultation document on the regulation of Medical Associate Professions. This prompted the author, an Advanced Critical Care Practitioner, to examine the regulation of Advanced Critical Care Practitioners in the past, present and future. National competence frameworks have been developed. However, there continued to be criticism on the lack of regulation and title protection of Advanced Critical Care Practitioners. This article discusses the response of governing bodies to the consultation and its potential future implications for Advanced Critical Care Practitioners.

Keywords

Advanced practice, critical care, regulation

Introduction

According to the Professional Standards Agency, the purpose of regulation is to minimise harm to the public and to reduce the likelihood of harm occurring.[1] Recently, the Department of Health (DOH) closed the consultation document on the regulation of medical associate professions in the UK and responses are planned to be published later in 2018.[2] This prompted the author, an Advanced Critical Care Practitioner (ACCP), to examine regulation of ACCP since undertaking this role in 2008. ACCPs are experienced healthcare professionals working with the acutely ill; they are able to diagnose, treat healthcare needs, prescribe and refer to appropriate specialties.[2] They are required to have an in-depth knowledge of the critically ill and collaborate with the multi-disciplinary team.[2]

Past

The development of ACCPs in the UK has gathered momentum in the last decade.[3] Their growth has been attributed to the implementation of the European Working Time Directive,[4] changes to the medical training outlaid in Modernising Medical Careers[5] and economic/staffing considerations.[6] It was also recognised that a shift towards community-based care was resulting in a higher proportion of sicker, dependent patients in hospital wards and this was attributed to an increase in demand for healthcare in the UK.[7] Consequently, the government's response was in promoting leadership and skills in advanced practice in order to ensure service delivery.[8] In response to this shortfall, many critical care units introduced new roles, extending the practice of technicians, physiotherapists, clinical pharmacists and nurses. According to the Department of Health,[8] advanced nursing practice could provide "high productivity and value for money." Many nurses embraced these new roles, recognising the potential for career development, whilst maintaining a clinical focus.

As the ACCP role developed, it was recognised that advanced practice roles were developing unsystematically and with little national strategic guidance.[9] Concern was raised on how competence would be regulated and verified.[6,10] This local focus on role development was nationally resulting in wide variations in clinical practice of ACCPs.[9] Disparities in education and training potentially could have resulted in confusion for patients and the public.[9] Publication of the National Education and

Adult Critical Care Unit, Wishaw General Hospital, Wishaw, UK

Corresponding author:
Johan Campbell, Adult Critical Care Unit, Wishaw General Hospital, Netherton Road, Wishaw ML2 0DP, UK.
Email: johan.campbell@btopenworld.com

Competence Framework for Advanced Critical Care Practitioners in 2008 specifically sought to address this.[9] It defined the role of the ACCP, its scope and limitations in clinical practice.[9] Describing a process of education, assessment and skills acquisition based on National Workforce Competences, this was intended to be nationally recognised and transferable.[9]

Strategic direction, specifically regulation of advanced practice, was recommended by the UK government and endorsed that the Nursing & Midwifery Council (NMC) should regulate advanced practice roles in England.[11] However, Scotland disagreed stating that governance should rest with the employers and commissioners, rather than the regulators. NHS Wales agreed, suggesting that organisations should ensure that robust governance strategies were in place prior to the development of these roles.[11] Meanwhile, nursing's statutory body, the NMC, despite acknowledging that regulation of advanced nursing practice could improve patient safety, did not recognise this as a priority.[12] Subsequently, regulation of advanced practice did not progress. Support for advanced practice regulation waned with a subsequent change in government, whilst the reduction of regulation became more of a priority.[13] It was suggested that advanced practice was a set of attributes describing expert practice, professional regulation on the grounds of risk was weak and the cost was unjustifiable.[14]

Present

There was a consensus among the UK health departments that master's level education would be expected for advanced practice roles;[15] however, a survey[16] found that under one third (n = 247) of advanced practice nurse respondents (n = 855) in the UK, had a master's degree. Surprisingly, the title of advanced nurse is not strategically recognised or governed in the UK.[17] Subsequently, the public could be left wondering what does the title "Advanced" actually mean. Analysis of pre-existing workforce data[18] demonstrated that advanced practice titles were being utilised by a host of healthcare staff; it found 595 differing job titles in use in the UK, in 17,960 specialist posts.[18] Disturbingly, 323 people holding specialist titles were not registered with the NMC.[18] It was argued that the lack of national regulation had led to poor role clarity, a wide discrepancy in practice and problems in tracking workforce data.[19] Perhaps more worrying was the issue of the scope of advanced practice and lack of regulation. Critics considered the subgroup of advanced practitioners carried a much greater degree of risk, highlighting that these "hybrid" practitioners undertake additional skills in aspects of medicine, including medical and diagnostic assessment, ordering/interpretation of clinical investigations, making independent clinical diagnoses and prescribing medical treatment.[14] It was argued that you would not allow a doctor to undertake these skills without proper regulation and education and ask "why then are we allowing nurses who are undertaking similar roles?"[14]

Official recognition of ACCP training with membership status has been offered by The Faculty for Intensive Care Medicine (FICM) since 2014.[20] ACCP curriculum was established the following year.[21] Currently, the role of ACCP is accessible to any UK registered professional, including nursing, physiotherapists and pharmacists; however, the vast majority are nurses.[22] Only individuals who are in a substantive ACCP role in the NHS or defence medical services are eligible to apply for the FICM membership, with attainment requiring[22]:

- The individual to have completed an ACCP training course to minimum of Post Graduate Diploma Level and
- the individual complete a training programme utilising the core and common competencies as set out in the National Competency Framework (2008).
- Following assessment and attainment of associate membership, the ACCP can demonstrate that training had been undertaken to a nationally agreed standard.

The FICM have issued a statement regarding the professional title ACCP, highlighting the title is associated with a clearly defined knowledge, skill and competency set and no other roles have this professional designation.[23] The FICM strongly endorsed that when recruiting ACCP applicants, they have attained FICM member status.[23] Currently, any individual beginning an ACCP training programme which does not meet the FICM specification will not be eligible for membership.[22] However, at present, application for membership remains entirely voluntary as they are not a regulatory body. However, one could argue that this approach provides a degree of role governance, transferability and standardisation.

Credentialing has also recently been introduced by the Royal College of Nursing.[24] Credentialing's intention is to allow nurses working at an advanced level to register their experience, competence and qualifications.[24] Once approved for the register, an employer, colleague or the public can access to verify an individual's credentials.[24] Credentialing requirements include[24]:

- Relevant master's qualification
- Non-medical prescribing qualification, registered with the NMC
- Registration with the NMC
- Job description which reflects the four pillars of advanced level practice, clinical practice, leadership, education and research.

Assessment of credentialing is undertaken by the RCN.[24] However for some ACCPs, this may pose a problem, as not all ACCPs are nurses. ACCPs undertake roles similar to a medical trainee. As the law currently stands, for any health professional who undertakes activities normally undertaken by another health professional, the law expects no lowering in the standard of that care.[25] Thus, ACCPs would be judged by the standard of a medical trainee. Who therefore should assess an ACCP's competence; the FICM or the RCN? Surely it is preferable that those who undertake roles under the auspices of medicine are assessed for competence by medicine. Both of these methods are not without cost; FICM – an annual subscription and RCN – an initial processing fee and three yearly subscriptions. It is unlikely that ACCP nurses will choose to undertake both.

Most recently, the Department of Health & Social Care published the Regulation of Medical Associate Professions in the UK consultation document.[2] Its intention is to seek views on the regulation of Medical Associate Professions (MAPs). Four groups are being considered in the consultation document, including: physician associate (PA), physician's assistant (Anaesthesia) (PA(A), surgical care practitioner (SCP) and ACCP. The consultation document sought views that the regulation of ACCP and SCP was not warranted.[2] It was considered that the ACCP and SCP roles are only undertaken by registered healthcare professionals and further regulation was not deemed necessary.[2] Consultation closed in December 2017; its outcome is expected later this year. However, consternation has been expressed in the medical and nursing communities. The FICM stated that they are "deeply disappointed" that ACCPs have not been recommended for regulation, as it fails to address the disconnection between regulation and existing clinical practice.[26] They suggest that the benefits of regulation include, improved patient safety, title protection, improved career pathways and would allow others beyond nursing and the allied health groups to become ACCPs.[26] Criticism has also been levied in the way each of the MAP groups has been seen as four separate professions. The General Medical Council (GMC) stated that the four groups should be considered as a "single umbrella profession" made up of four areas of practice.[27] They highlight that statutory regulation of all four groups would provide greater clarity and assurance for the public and employers.[27] They emphasised that although ACCPs may be regulated by other bodies (HCPC and NMC), there may be no connection with their scope of practice and the scope of practice they may be regulated in.[27] The GMC considered they would be best placed to provide professional regulation.[27] The Royal College of Anesthetists provides a similar response, highlighting that the importance of the titles "Physician's assistant (anesthesia)" and "Advanced Critical Care Practitioner" should be safeguarded and that only statutory regulation could provide this level of guarantee.[28]

The RCN criticised the consultation on presenting the four groups as being substantially different.[29] They considered as the physician associate role becomes established in healthcare, that these skills could be transferred across all four MAP groups and this could lead to a more flexible workforce.[29] The RCN also highlighted that there is a belief that ACCPs should be aligned with a medical Royal College, but practitioners are functioning by virtue of their original registration.[29] Currently, nurse ACCPs are accountable to the NMC code and regulations, not to the Royal College.[29] They suggested that as an ACCP can be an intensive care unit (ICU) resident, statutory regulation is warranted for this role.[29] Both the RCN[29] and the NMC[30] highlighted the challenge of co-existing registration when introducing potential new statutory regulation to individuals with existing professional registration. This would require clarification on how this would be managed. The NMC stressed that if a different regulator was introduced for ACCP roles, they would be required to give up NMC registration and to continue to practise as a nurse.[30] Additionally, dual registration may be required and this could lead to confusion for the individual and the public.[30] Furthermore, the NMC stated the government needed to consider if ACCP roles are advanced nursing practice roles, requiring further regulation, or if they wish MAP roles to be open to others who are not regulated professionals, the government may consider this as a new profession.[30] However, the Professional Standards Authority advises caution, suggesting that there is little persuasive evidence of risk of actual harm, which cannot be moderated through established regulatory pathways.[1] They highlighted that ACCPs are already registered healthcare professionals.[1] Adding that this may lead to widespread calls for regulation from other healthcare groups and warn regulation can be rigid, expensive or even counterproductive if used inappropriately.[1]

Future

ACCPs have become embedded in ICUs and it is recognised that future workforce requirements will increasingly rely on their skills and expertise as the pressure on intensive care beds continues to increase. I began my journey as an ACCP in 2008 with much excitement and trepidation. Very much in its infancy, it was not clear what the ACCP role entailed, nor what barriers to practice existed. My role development was guided by strategic regional governance, competencies influenced by DOH ACCP guidelines,[9] multi-disciplinary support, consultant anaesthetist clinical supervision and a master's level education. With title protection of ACCP, we are clearly

demonstrating to the professions and the public what level of education and competence the individual has attained. The difficulty in tracking workforce data without regulation has been highlighted; surprisingly, no mention of Scottish ACCPs was noted in the governments' consultation document,[2] despite its clear remit of the UK. The rationale for this is unclear and perhaps their numbers are unknown. Not all ACCPs are currently registered with the FICM. If legislation continues with the current position, we will never know how many ACCPs are in the UK, as registration is entirely voluntary. The study examining workforce titles highlighted that the titles utilised are not always reflective of the individual's competence.[18] In protecting the ACCP title, we are protecting the specialty, ensuring that ACCPs are academically prepared, and more importantly, we are protecting the public.

The question on whether ACCPs should be regulated and by whom, is not easily answered. Arguably for nurses, responsibility for competence does exist with the NMC code, as all registered nurses are required to revalidate every three years and prove they are meeting the standards identified in the NMC code, including "recognise and work within the limits of your competence."[31] However, as many of ACCP skills come under the auspices of medicine, the argument for them to regulate under the umbrella of MAPs is important. Nonetheless, surrendering NMC registration for GMC registration would be a monumental decision. Becoming a potential ACCP would no longer be simply career progression in nursing; however, it may result in nurse ACCPs having reduced career pathways and unable to utilise their skills in the nursing profession at a future date. Transferring registration could be viewed as a disincentive. The author agrees that the protection of the title ACCP is necessary; however, regulation as MAPs could be detrimental to the career progression of nurses. Of equal importance is the proposal of entry to ACCP roles outwith the health professions.[22] As suggested by the RCN,[29] the four MAP groups do have skills that are transferrable and this would allow the workforce potential for MAPs to be more diverse. However, by definition, ACCPs are "experienced health care professionals"[2] and in opening the route to others without critical care experience, there is a danger that this "experience" is devalued. Much of what ACCPs do can be learned academically; however, much of what they deliver comes from their previous experiences in critical care. The government response on MAPs will be released later this year, and it is hoped that the decision for ACCPs is not counterproductive.

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